CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-0391	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIHIDDIC	00	COMPLETED 07/10/2012	
		155773	A. BUILDING			
			B. WING	ADDRESS CITY STATE 7IB CORE		
NAME OF F	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
				CDOWELL RD		
TERRAC	E AT SOLARBRON	NIHE	EVANS	VILLE, IN 47712		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0000						
	This wisit was fo	or the Investigation of	F0000			
		or the Investigation of	1 0000			
	Complaint IN00	109929.				
	Complaint IN00	109929 Substantiated,				
	_	ficiencies related to the				
	allegations are c					
	allegations are c	ited at 1203.				
	Unrelated defici	encies cited.				
	Survey date:					
	July 10, 2012					
	July 10, 2012					
	Facility number:					
	Provider number	r: 155773				
	AIM number: N	7/A				
	C					
	Survey team:					
	Anne Marie Cra	ys RN				
	Census bed type	: :				
	SNF: 23					
	Residential: 30					
	Total: 53					
	Census payor ty	pe:				
	Medicare: 9					
	Other: 44					
	Total: 53					
	Sample: 3					
	These deficienci	ies also reflect state				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/27/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155773	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 07/1	TE SURVEY TPLETED 10/2012
	PROVIDER OR SUPPLIER E AT SOLARBRON THE	1701 M	ADDRESS, CITY, STATE, ZIP CO CDOWELL RD SVILLE, IN 47712	ODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	findings cited in accordance with 410 IAC 16.2.				
	Quality review completed 7/15/12 Cathy Emswiller RN				

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Event ID: 74BQ11

Facility ID: 010930

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DDIC	00	COMPL	ETED
		155773	A. BUII			07/10/	2012
			B. WIN		PDDEGG CUTY GTATE ZID GODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
TEDD 4 01	E AT OOL ADDDON				CDOWELL RD		
TERRACI	E AT SOLARBRON	ITHE		EVANS	VILLE, IN 47712		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
F0203	483.12(a)(4)-(6)						
SS=E		REMENTS BEFORE					
	TRANSFER/DIS						
		ransfers or discharges a					
		lity must notify the resident					
		family member or legal					
		the resident of the transfer the reasons for the move in					
		anguage and manner they					
		ord the reasons in the					
		I record; and include in the					
		described in paragraph (a)(6)					
	of this section.	1 3 1 ()()					
	Except when spe	ecified in paragraph (a)(5)(ii)					
		ne notice of transfer or					
		ed under paragraph (a)(4) of					
		be made by the facility at					
		fore the resident is					
	transferred or dis	scnarged.					
	Notice may be m	ade as soon as practicable					
	•	r discharge when the health					
		he facility would be					
		er (a)(2)(iv) of this section;					
		alth improves sufficiently to					
		nediate transfer or					
	discharge, under	paragraph (a)(2)(i) of this					
	section; an imme	ediate transfer or discharge is					
		esident's urgent medical					
		ragraph (a)(2)(ii) of this					
		dent has not resided in the					
	facility for 30 day	/S.					
	The written nette	a appointed in paragraph (a)					
		e specified in paragraph (a)					
		n must include the reason for arge; the effective date of					
		arge; the location to which					
		ansferred or discharged; a					
		e resident has the right to					
		n to the State; the name,					
		phone number of the State					
		•	1				l l

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Event ID: 74BQ11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155773	B. WING		07/10/2012
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
TEDDAG		U TUE		ACDOWELL RD	
	E AT SOLARBROI			SVILLE, IN 47712	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
		NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		CROSS-REFERENCED TO THE APPROPRIA	
TAG	long term care of facility residents disabilities, the residents of the protection developmentally established und Developmental Bill of Rights Acresidents who a address and tele responsible for of mentally ill independent of mentally ill independent of the Protection and Individuals Act. Based on intervifacility failed to notice of transfer residents and far for transfer notice. Residents A, B, Findings included 1. The closed clip A was reviewed Diagnoses inclusted, dementia and A "Notice of Traindicated, "Date year)" The date A Nurse's Note, A.M., indicated,	Disabilities Assistance and t; and for nursing facility re mentally ill, the mailing ephone number of the agency the protection and advocacy dividuals established under and Advocacy for Mentally Ill ew and record review, the provide a completed ror discharge to 3 of 3 mily members sampled tes, in a sample of 3. and C e: Inical record of Resident on 7/10/12 at 10:45 A.M. ded, but were not limited a stroke. Instead (month, day, e was left blank. dated 5/31/12 at 11:30 "Resident d/c'd m facility. [Facility] van	F0203	F203 By submitting the enclar material we are not admitting truth or accuracy of any specifindings or allegations. We reserve the right to contest the findings or allegations as part any proceedings and submit these responses pursuant to regulatory obligations. The fact request that the plan of correct be considered our allegation of compliance effective July 27, 2012 to the complaint survey conducted on July 10, 2012. What corrective action(s) with be accomplished for those residents found to have been affected by the deficient practice? Resident's A, B, and no longer reside at the facility. How will other residents have the potential to be affected by the deficient practice identified and what corrective actions will be taken? All discharged residents have the potential to beaffected by the	osed the fic e of our cility ction of

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155773	B. WIN			07/10/	2012
		_	-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	R		1701 M	CDOWELL RD		
TERRAC	E AT SOLARBRON	N THE			VILLE, IN 47712		
(VA) ID	CLIMMADY C	TATEMENT OF DEFICIENCIES		ID	,		(V.5)
(X4) ID PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	, and the second	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
TAG		*		TAG	alleged deficient practice. Nur	2000	DATE
	1	Bed hold policy [and]			and Social Services have been		
		r [and] discharge given to			in-serviced that the Notice of		
	resident"				Transfer or Discharge - State		
					Form 49669 shall be complete	ed	
	During interviev	v with the MDS			in its entirety and and a copy s		
	1 -	7/10/12 at 12:00 P.M., she			be provided to the resident an	d	
		charging nurse fills out 2			the resident's representative.		
					original 49669 will be maintain		
	_	nsfer notice, gives one to			by on the medical record and a		
		leaves a copy in the chart.			copy will be maintainedby Soc		
	She indicated the	e notice should have been			Services to monitor and identif	У	
	complete, includ	ling the date.			any further alleged deficit practices. Deficit practices sha	ıll	
	_	_			be immediately reported to the		
	During interview	w with the Administrator			Administrator for corrective	,	
	_				action. What measures will	be	
		50 P.M., she indicated she			put into place or what system		
	_	e resident to the new			changes will be made to		
	1	ded the facility the			ensure that the deficient		
	paperwork to give	ve to the family, including			practice does not recur?		
	the notice of tran	nsfer and discharge. The			Nursing staff have been		
	Administrator in	dicated nursing should			in-serviced regarding the		
	fill out 1 Notice	of Transfer or Discharge			completion of the Notice of Transfer or Discharge State Fo	orm	
		ent and family, and then			49669 in its entirety. Nursing s		
		the clinical record.			have been in-serviced to make		
	make a copy for	the chinical record.			copies ofthe original documen		
					and maintaining the original		
		w with the resident's POA			document on the medical reco	rd	
	on 7/10/12, she	indicated she never			and the requirement that a cor		
	received a notice	e of transfer or discharge.			be given to the resident and th		
					resident's representative upon		
	2. The closed cli	inical record of Resident			discharge. A copy of the origin	ial	
		on 7/10/12 at 12:15 P.M.			49669 will be maintained by Social Services to identify any		
	- was it viewed	on // 10/ 12 at 12.13 1.1vi.			further alleged deficit practice.		
	A IDIT (6 D: 1 "			Deficit practices shall be		
		ansfer or Discharge,"			immediately, or as practicable		
	dated 7/5/12, inc	cluded: "Reason for			reported to the Administrator for		
	Transfer or Disc	harge (must select one of			corrective action. Quality		
	the reasons belo	w)" None of the			assurance measures will be		
l	I		1				

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Event ID: 74BQ11

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If continuation sheet

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155773 A. BUILDING B. WING 00 07/10	
B. WING	/2012
STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER 1701 MCDOWELL RD	
TERRACE AT SOLARBRON THE EVANSVILLE, IN 47712	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	COMPLETION
The Added the Added and the Added the Added to the Added	DATE
statements were enecked. 2 copies of the	
transfer notice were included in the	
clinical record. A note was taped on one deficient practice will not recur,	
of the notices which indicated, "What to ie, what quality assurance	
check?" program will be put into place? Social Services will present a	
copy of the completed Notice of	
A Nurse's Note, dated 7/3/12 at 9:30 Transfer or Discharge of	
A.M., indicated, "Res. [resident's] son discharged residents of which will	
given copy of bed hold policy [and] be reviewed weeklyX 1 year by	
notice of discharge" the Interdisciplinary Team. Social Services shall report findings of	
deficit practices immediately or as	
During interview with the Administrator practicable to the Administrator	
on 7/10/12 at 1:50 P.M., she indicated the for corrective action. The	
notice should have been completed. The Administrator will report the	
Administrator indicated she did not know findings to the Quality Assurance Team for recommendations at	
why there were 2 copies in the chart. the next scheduled quarterly meeting X 1 year.	
3. The closed clinical record of Resident	
B was reviewed on 7/10/12 at 11:50 A.M.	
A "Notice of Transfer or Discharge,"	
dated 7/5/12, included: "Reason for	
Transfer or Discharge (must select one of	
the reasons below)" None of the	
statements were checked.	
Sales Hold Shoulds.	
During interview with the Administrator	
on 7/10/12 at 1:50 P.M., she indicated the	
notice should have been completed. She	
indicated she planned on having the	
Social Services Director start filling them	
out.	
This federal tag relates to Complaint	

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PRINTED: 07/27/2012 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155773	A. BUILDING	00	COMPLETED 07/10/2012	
		100773	B. WING		0771072012	
NAME OF P	ROVIDER OR SUPPLIER	1		ADDRESS, CITY, STATE, ZIP CODE		
TERRACE AT SOLARBRON THE				CDOWELL RD VILLE, IN 47712		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	<u> </u>	(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	IN00109929.					
	3.1-12(a)					

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Event ID: 74BQ11

Facility ID: 010930

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STATEMEN	T OF DEFICIENCIES	EFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SU			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155773	B. WIN			07/10/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				CDOWELL RD		
TEDDAC	E AT SOLARBRON	ITHE			VILLE, IN 47712		
				LVANO	· · · · · · · · · · · · · · · · · · ·		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0282 SS=D	CARE PLAN The services pro facility must be p in accordance wi	QUALIFIED PERSONS/PER ovided or arranged by the provided by qualified persons with each resident's written					
	plan of care.						
	facility failed to regarding leaving the bathroom, resemergency room residents reviewed of care, in a sample Findings include The closed clinic was reviewed on	eal record of Resident A 7/10/12 at 10:45 A.M. led, but were not limited	F02	82	F282 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident in longer resides at the facility. The Certified Nursing Assistant involved in the incident is no longer employed by the facility. How will other residents have the potential to be affected by the same deficient practice by identified and what corrective actions will be taken? A revise of all residents medical records and Care Sheets were completed to ensure the Care Sheets accurately reflected the Plan of	"A" /. int /. ing be ee ee ee eted	07/27/2012
	2/28/12, indicate for fall related in Fall Risk factors Fall Risk Screen [hypertension] C CVA, hemipares CVA, gait disturbant An admission M assessment, dated resident required	hary Care Plan, dated d a problem of "At risk jury as evidenced by: present as determined by Related to:HTN onfusion [secondary to] is [one-sided weakness] - b [sic]" inimum Data Set [MDS] d 3/15/12, indicated the extensive assistance of ansfer and toilet use, and			Care. A nursing in-service was conducted regarding the complaint survey which include fall prevention, keeping reside free from accidents hazards as possible, following Resident C Sheet guidelines, following Physician Orders as directed a well as the completion of the Notice Transfer or Discharge State Form 49669. What measures will be put into plator what systemic changes who be made to ensure that the deficient practice does not recur? The Care Sheets will be reviewed in the daily IDT	ed nts s is are as	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	DDIG	00	COMPLI	ETED
		155773		LDING		07/10/	2012
			B. WIN		A DDDDGG GYEV GEATER GID GODE		
NAME OF I	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE		
TEDDAG	NE AT OO! ADDDO	NI TI IE			CDOWELL RD		
TERRAC	E AT SOLARBRO	N THE		EVANS	VILLE, IN 47712		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	did not ambulat	e. A test for balance			meetings ensure it accurately		
	indicated, "Not	steady, only able to			reflects the Plan of Care and		
		uman assistance" while			updated Physician Orders.		
		off toilet. The MDS			Quality Assurance procedures be followed as outlined below.		
	_	cated the resident had			Upon an occurrence of a resid		
					fall, a resident willbe reassess		
		onth prior to admission,			and the incident will be review		
		since admission to the			at the daily (M-F) Interdisciplir	nary	
	facility.				Team meeting to determine th	ie	
					root cause analysis of the fall		
	A Physician's of	rder, dated 4/18/12 and on			review the intervention. Prop		
	the May 2012 orders, indicated, "Do not				interventions will be put in place	ce	
	1	d in BR [bathroom]."			and the Care Sheet will be updated as appropriate. Hov	,	
		a in Bit [outin coin].			will the corrective action be	'	
	A Fall Dials Aga	aggment dated 5/12/12			monitored to ensure the		
		sessment, dated 5/13/12,			deficient practice will not red	cur.	
		sident had intermittent			ie, what quality assurance	,	
		a history of 3 or more falls			program will beput into plac	e?	
	in the previous	3 months, required the use			A Performance Improvement		
	of assistive dev	ices, and had a total score			Tool has been initiated that		
	of 19 ["Total sc	ore of 10 or above			randomly audits of 5 residents		
	_	H RISK" of falls].			weekly, X3 monthly, X3 quarte X1 year will be conducted by the		
	1				Director of Nursing or designe		
	Nurses Notes in	cluded the following			ensure the fall prevention		
		icided the following			measures are being utilized,		
	notations:				Physician Orders and Care		
					Sheets are being followed.		
		A.M.: "Called to [room			Findings from the audit will be		
		A to check area where Res			reviewed by the Interdisciplina		
	[resident] had a	n old skin tear. CNA			Team X3 weekly, X3 monthlya X3 quarterly. Findings will be	ai i U	
	exiting Rm [roc	om] as I entered. CNA			submitted to the the		
	stated 'She is or	the toilet.' I approached			QualityAssurance Team quart	erly	
		c] bathroom [and]			X 1 year for further	·	
	_	nt on the floor beside			recommendations.		
		oe assessment revealed					
	-	between raised area on					
	left shoulder [and] raised area below left					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155773			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/10/2012
	PROVIDER OR SUPPLIEI		1701 M	ADDRESS, CITY, STATE, ZIP CODE CDOWELL RD SVILLE, IN 47712	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	noted on left parareaModerate noted left paritia until bleeding st include a small l knee [and] small forearm911 no physician] and F meet res @ [hos 5/22/12 at 9:00 A ER. Only new o no shampoo X 4 abrasion to [left] cm [centimeters Also rec [receive elbow 1.6 x 0.3] During interview on 7/10/12 at 1::	amt [amount] of bleeding all [sic] area. Pressure held opped. Other areas accration noted on left abrasion noted on left of tified. [Name of POA notified [and] will pital]." A.M.: "Res returned from order may rinse hair now; 8 [hours]. Res has head upper forehead 3 x 1.8 and a upper forehead 3 x 1.8 and			

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155773	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	E SURVEY PLETED 0/2012
	PROVIDER OR SUPPLIER E AT SOLARBRON THE	1701 M	ADDRESS, CITY, STATE, ZIP CO CDOWELL RD VILLE, IN 47712	DDE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE

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Event ID: 74BQ11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE S		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUILDING	COMPLETED	
		155773	A. BUILDING B. WING	00	07/10/2012
				ADDRESS, CITY, STATE, ZIP CODE	<u>l</u>
NAME OF I	PROVIDER OR SUPPLIEF	t .		ACDOWELL RD	
TERRAC	CE AT SOLARBRON	I THE		SVILLE, IN 47712	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0323 SS=G	483.25(h) FREE OF ACCII HAZARDS/SUP The facility must environment ren hazards as is poreceives adequate assistance device. Based on intervifacility failed to for falls was supcommode, result emergency room residents review of 3. Resident A Findings include The closed clinical was reviewed on Diagnoses include to, dementia and An Interdiscipling 2/28/12, indicated for fall related in Fall Risk factors Fall Risk Screen [hypertension] C CVA, hemipares CVA, gait disturtion and the second control of the control of t	DENT ERVISION/DEVICES ensure that the resident hains as free of accident ssible; and each resident the supervision and these to prevent accidents. ew and record review, the ensure a resident at risk the ervised while on the ting in a fall and the treatment, for 1 of 1 the end for falls, in a sample the accord of Resident A to 7/10/12 at 10:45 A.M. the end but were not limited stroke. The end of "At risk tigury as evidenced by: the present as determined by the end of the end to the end of	F0323	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident "A" no longer employed by the facility. The Certified Nursing Assistant involved in the incident is no longer employed by the facility. How will other residents have the potential to be affected by the same deficient practice in identified and what corrective actions will be taken? An action will be taken? An acti	n o7/27/2012 n oger y. ving be ve udit e as e de e are A I e e ie vice
l	resident required	extensive assistance of			ina
	was reviewed on Diagnoses included to, dementia and An Interdiscipling 2/28/12, indicated for fall related in Fall Risk factors Fall Risk Screen [hypertension] CCVA, hemipares CVA, gait disturn An admission Massessment, date	ded, but were not limited stroke. The arry Care Plan, dated and a problem of "At risk adjury as evidenced by: present as determined by Related to:HTN confusion [secondary to] aris [one-sided weakness] - b [sic]"		identified and what corrective actions will be taken? An actions will be taken? The propriete interventions were appropriate interventions with identified need of additional preventative interventions will have the additional interventions documented on the Plan of Catand Resident Care Sheets. A review of all residents medical records and Care Sheets were completed to ensure the Care Sheets accurately reflected the Plan of Care. A nursing in-ser was conducted regarding the complaint survey which include	ve udit e as e d e are A I e e e vice

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STATEMENT OF DEFICIENCIES X1) PROVIDER/S		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		a. building 00		COMPLETED	
155773		B. WING			07/10/2012		
			Б. үүнү		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				1701 MCDOWELL RD			
TERRACE AT SOLARBRON THE			EVANSVILLE, IN 47712				
					······································		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG			
	two+ staff for transfer and toilet use, and				Resident Care Sheet guideline	es,	
	did not ambulate	. A test for balance		following Physician Orders		ion	
	indicated, "Not steady, only able to			directed as well asthe completion of State Form 49669. What measures will be put into place or what systemic changes will		ion	
	stabilize with human assistance" while					CO	
	moving on and off toilet. The MDS						
	assessment indicated the resident had			be madeto ensure that the			
	fallen in the month prior to admission, and had fallen since admission to the				deficient practice does not recur? Residents Fall Risk		
					Assessments will be reviewed		
	facility.			uponadmission and appropria			
					fall prevention measures will be		
	A Physician's order, dated 4/18/12 and on				put intoplace for those scoring as		
	the May 2012 orders, indicated, "Do not			"High Risk". Upon an occurrence			
	leave unattended in BR [bathroom]."			of aresident fall, a resident will be reassessed and the incident will			
	l cave unattended	in BK [batinooni].		be reviewed at the daily		"	
	A Fall Risk Assessment, dated 5/13/12, indicated the resident had intermittent confusion, had a history of 3 or more falls in the previous 3 months, required the use of assistive devices, and had a total score of 19 ["Total score of 10 or above represents HIGH RISK" of falls]. Nurses Notes included the following notations: 5/22/12 at 4:50 A.M.: "Called to [room number] by CNA to check area where Res [resident] had an old skin tear. CNA exiting Rm [room] as I entered. CNA stated 'She is on the toilet.' I approached the residents [sic] bathroom [and]				Interdisciplinary Team meeting	ı to	
					determine the root cause analy		
					of the fall and review the		
				intervention. The Care Shee also reviewed in the IDT meetingsto ensure it accurat		vill	
					reflects the Plan of Care. Qua	lity	
					assurance methods will be followed as outlined below.	low	
					will the corrective action be	OW	
					monitored to ensure the		
					deficient practice will not rec	ur.	
				ie, what quality assurance		,	
					program will be put into plac	e?	
					A Performance Improvement		
					Tool has been initiated that		
					randomly audit of 5 residents >		
					weekly, X3 monthly, X3 quarte		
					X1 year will be conducted by the Director of Nursing or designed		
					insure the fall prevention	5 10	
					measures are being utilized,		
observed resident on the floor beside toilet. Head to toe assessment revealed depressed area between raised area on				Physician Orders and Care			
				Sheets are being followed.			
				Findings from the audit will be			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155773		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		(X3) DATE SURVEY COMPLETED 07/10/2012	
		100110	B. WING	ADDRESS STORY STATE STR. SODE	0771072012
NAME OF I	PROVIDER OR SUPPLIE	₹		ADDRESS, CITY, STATE, ZIP CODE MCDOWELL RD	
	E AT SOLARBRON	NTHE		SVILLE, IN 47712	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
TAG	[left] shoulder [a shoulder. Denied noted on left par areaModerate noted left paritia until bleeding strinclude a small l knee [and] small forearm911 no physician] and P meet res @ [hos 5/22/12 at 9:00 A ER. Only new on o shampoo X 4 abrasion to [left] cm [centimeters Also rec [receive elbow 1.6 x 0.3 doi: 10.00 physician] and P meet res @ [hos 5/22/12 at 9:00 A B abrasion to [left] cm [centimeters Also rec [receive elbow 1.6 x 0.3 doi: 10.00 physician] and P meet res @ [hos 5/22/12 at 9:00 A B abrasion to [left] cm [centimeters also rec [receive elbow 1.6 x 0.3 doi: 10.00 physician] at 1.50 physician are physician at 1.50 physician at 1.	and] raised area below left d pain to that areaBlood ential [sic] amt [amount] of bleeding l [sic] area. Pressure held opped. Other areas accration noted on left abrasion noted on left of tified. [Name of POA notified [and] will pital]." A.M.: "Res returned from reder may rinse hair now; 8 [hours]. Res has head upper forehead 3 x 1.8 [l-monitor q [every shift. ed] skin tear to [left] cm" We with the Administrator of P.M., she indicated the have left Resident A	TAG	reviewed by the Interdisciplina Team X3 weekly, X3 monthlya X3 quarterly. The Administrate will submit the findings to the to QualityAssurance Team quart X 1 year for further recommendations.	DATE ary and or the
ĺ					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
155773		A. BUILDING B. WING 00 07/10/2012					
NAME OF D	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE			
			1701 MCDOWELL RD				
	E AT SOLARBRON		ID PROMISERS IN AN OF CORRECTION (X5)				
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION			
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE		
		·					

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